TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE NORTH DALLAS

Respondent Name
EMPLOYERS INSURANCE COMPANY OF WAUSAU

MFDR Tracking Number
M4-17-0632-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Fee Schedule was updated 7/1/2015. CPT codes 99213 and 97110 were not paid with the correct price. The Fee Schedule guidelines state to 'ROUND UP' but the payee [*sic*] did not do so. Please see attached."

Amount in Dispute: $0.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Only the last 5 lines of the list of disputed services are even eligible for dispute resolution so the total in dispute is actually .05 . . . We believe that these services were reimbursed according to the medical fee guidelines."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2015 to December 30, 2015	Professional Medical Services, Evaluation and Management Code: 99213	$0.65	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. The request for medical fee dispute resolution was received on November 4, 2016.
4. Dates of service July 15, 2015 through October 20, 2015 fall outside the one year filing limit for requesting medical fee dispute resolution, and therefore those disputed services cannot be considered in this review.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - P300 – charge exceeds fee schedule maximum allowable or contracted/legislated fee arrangement.

Issues

1. Has the requestor met the timely filing limits for requesting medical fee dispute resolution?
2. What is the recommended reimbursement for the disputed professional medical services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request."

   Rule §133.307(c)(1)(A) further states that: "A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The disputed dates of the service are from July 15, 2015 through December 30, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on November 4, 2016. This date is later than one year after the date(s) of service in dispute.

   Review of the submitted documentation finds that the disputed services do not involve issues identified in Rule §133.307, subparagraph (B).

   The division concludes that the requestor has failed to timely file the dispute for dates of service July 15, 2015 through October 20, 2015 with the division's MFDR Section; consequently, the requestor has waived the right to MFDR for those services, and those dates of service will not be considered in this review.

   However, the request for medical fee dispute resolution was timely filed with respect to dates of service November 4, 2015 through December 30, 215. Those dates are eligible for review and are considered below.

2. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

   > To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . . .
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor. The applicable division conversion factor for calendar year 2015 is $56.20.

   The requestor maintains that "CPT codes 99213 and 97110 were not paid with the correct price. The Fee Schedule guidelines state to 'ROUND UP' but the payee [*sic*] did not do so."

   The respondent asserts, "We believe that these services were reimbursed according to the medical fee guidelines."

In calculating the fees below, standard rounding rules have been applied. Where a calculation would produce a remainder of a fractional cent, the result has been rounded to the nearest whole cent in accordance with Medicare payment policy. See *Medicare Claims Processing Manual*, Chapter 12 – Physicians/Nonphysician Practitioners, Section 20.1 regarding "Method for Computing Fee Schedule Amount"

Reimbursement is calculated as follows:

- For procedure code 99213, service date November 4, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.98746. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.009 is 1.01909. The malpractice RVU of 0.06 multiplied by the malpractice GPCI of 0.772 is 0.04632. The sum of 2.05287 is multiplied by the division conversion factor of $56.20 for a MAR of $115.37.
- For procedure code 99213, service date November 5, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.98746. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.009 is 1.01909. The malpractice RVU of 0.06 multiplied by the malpractice GPCI of 0.772 is 0.04632. The sum of 2.05287 is multiplied by the division conversion factor of $56.20 for a MAR of $115.37.
- For procedure code 99213, service date November 24, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.98746. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.009 is 1.01909. The malpractice RVU of 0.06 multiplied by the malpractice GPCI of 0.772 is 0.04632. The sum of 2.05287 is multiplied by the division conversion factor of $56.20 for a MAR of $115.37.
- For procedure code 99213, service date December 16, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.98746. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.009 is 1.01909. The malpractice RVU of 0.06 multiplied by the malpractice GPCI of 0.772 is 0.04632. The sum of 2.05287 is multiplied by the division conversion factor of $56.20 for a MAR of $115.37.
- For procedure code 99213, service date December 30, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.98746. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.009 is 1.01909. The malpractice RVU of 0.06 multiplied by the malpractice GPCI of 0.772 is 0.04632. The sum of 2.05287 is multiplied by the division conversion factor of $56.20 for a MAR of $115.37.

3. The total allowable reimbursement for the services in dispute is $576.85. The insurance carrier has paid $576.85. The amount due to the requestor is $0.00.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 9, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.